Wyoming Department of Health
Wyoming Medication Donation Program

# Contents of Application

**Page 1: Demographic information**

- Fill out all fields, including medication allergy information
- If your mailing address and physical address are not the same, please specify in the corresponding fields
- Sign at the bottom of the page (required)

**Page 2: Insurance and Income Information**

- Check all boxes that apply for sources of income and fill out the income detail section
- Specify the number of adults and children in your household

**Page 3: Prescription information**

- Include pharmacy information (so that we may transfer the prescription to us)
- Include doctor information (so that we may contact the doctor for new prescriptions or questions)

**Pages 4-9: Notice of Privacy Practices**

- Information for you about how your medical information will be handled by the program
- Only page 9 needs to be signed and returned to us (pages 4-8 can be retained by you for your records)

**Page 10: Instructions for Proofs of Income and Residency**

**Page 11: Statement Regarding No Income**

**Page 12: Residency Verification**

**How to Submit Your Application and Documents:**

Fax: (307) 635 - 2156

**•••OR•••**

Email: wdh-rxdonationinfo@wyo.gov

**•••OR•••**

Mail: Wyoming Medication Donation Program
2300 Capitol Avenue
Hathaway Bldg., Suite B27
Cheyenne, WY 82002

*****Only return pages 1, 2, 3, 9, 11 (if applicable), and 12 (if applicable) *****

**Call if you have questions!**
(307)-635-1297 OR Toll Free at (855)-257-5041
www.wyomedicationdonation.org
Monday – Friday 9:00am-3:00pm

# Application for Eligibility

Wyoming Department of Health
Commit to your health.


**Wyoming Medication Donation Program**
2300 Capitol Avenue
Hathaway Bldg., Suite B27
Cheyenne, WY 82002
Phone:307-635-1297
Toll Free: 1-855-257-5041
Fax: 307-635-2156
www.wyomedicationdonation.org


**Agency Use:**
Referred by: _____
☐ Wyoming Resident
☐ Listed sources of income
☐ Insurance status specified

Start date: ___/___/___ End date: ___/___/___

Authorized Representative: _____

| Today's Date: | Last Name: | First Name: | Middle Name: |
|---|---|---|---|
| | | | |

| Date of Birth: / / | Gender: ☐ Male ☐ Female | Other names (ex: maiden name, nickname, etc.): |
|---|---|---|
| | | |

Mailing Address:

| City: | State: | Zip Code: |
|---|---|---|
| | | |

Physical Address (if different from mailing address)

| City: | State: | Zip Code: |
|---|---|---|
| | | |

| Home Phone Number: ( ) - | Cell Phone Number: ( ) - | Social Security Number: - - |
|---|---|---|
| | | |

Are you allergic to any medication? ☐ Yes ☐ No

If yes, please list out your allergies:

Race (check one): ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ White ☐ 2 or More ☐ Other

Primary Language (check one): ☐ English ☐ Spanish ☐ Other:

Marital status (check one): ☐ Married ☐ Single

## *Release Form – Acknowledgement of Donation*

- *My signature indicates that all of the information I have provided is true and correct. I hereby grant permission to this agency to obtain and share the information I have provided for the purpose of determining eligibility for assistance.*
- *I acknowledge that the medication I receive through this program was originally dispensed to another patient and has been donated to the Wyoming Medication Donation Program for re-dispensing.*
- *In accordance with the Drug Donation Program Act and the Administrative Procedures Act W.S. § 16-3-10; I understand that any person or entity which exercises reasonable care in donating, accepting, distributing, dispensing medications under the Drug Donation Program Act or rules and regulations adopted and promulgated under this act shall be immune from civil or criminal liability or professional disciplinary action of any kind for any related injury, death, or loss.*

Wyoming Department of Health
Commit to your health.

Signature of Applicant: _____ Date: _____

**** In order to be approved for the Wyoming Medication Donation Program, your signature is required ****

## Insurance and Income Information

*** Please Fill Out All Portions ***

**Insurance Coverage:** Are you covered by any of the following forms of insurance?

| | | | |
|---|---|---|---|
| Private Insurance (medical) | ☐ Yes ☐ No | ID#: | Company: |
| Private Insurance (prescription) | ☐ Yes ☐ No | ID#: | Company: |
| Medicare Part A/B | ☐ Yes ☐ No | ID#: | Company: |
| Medicare Part D | ☐ Yes ☐ No | ID#: | Company: |
| Medicaid (any state) | ☐ Yes ☐ No | ID#: | Company: |
| VA Benefits | ☐ Yes ☐ No | ID#: | Company: |

**If yes to any of the above, why are you applying to WMPD?**

**Employment Status (check one):**

| | | | | |
|---|---|---|---|---|
| ☐ Full time | ☐ Part time | ☐ Unemployed | ☐ Student | ☐ Retired |

**Who referred you to the WMDP (how did you hear about the program)?**

***Check ALL sources of income***

| | | | |
|---|---|---|---|
| ☐ Alimony | ☐ Pension payments | ☐ Disability payments | ☐ Wages |
| ☐ Child Support | ☐ Public Assistance | ☐ SSDI payouts | ☐ Workmen's Comp |
| ☐ Food Stamps | ☐ Rental property income | ☐ Unemployment benefits | ☐ Other: |
| ☐ Interest/Investments | ☐ Social Security payments | ☐ VA benefits | |

How many people are supported by this income? Adults: _____ Children (under 18 years old): _____

Check your residence status: ☐ Own(mortgage) ☐ Rent(lease) ☐ Live with friend/family/roommate ☐ Shelter/facility

**Income Detail:**

(if married, list spouse income also)

| Employer/Income Source | Amount | Pay Frequency | Income Paid To Whom |
|---|---|---|---|
| | $ | | |
| | $ | | |
| | $ | | |
| | $ | | |
| | $ | | |
| | $ | | |

## Prescription Information

| | |
|---|---|
| Primary Doctor's Name: | |
| Phone number: (  )  - | Fax number: (  )  - |
| Do you see more than one doctor? ☐ Yes ☐ No | |

| **Medication Name and Strength:** (list *all* medications you take) | **Directions for use:** | **Doctor:** (please specify) |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

**!!! A valid prescription is required to receive medications from WMDP!!!**

## Please Choose One Option Below:

☐ Original Rx included with the application (faxed copy from a patient is not acceptable)

☐ Please transfer the refill from my local pharmacy

Name of Pharmacy: _____

Pharmacy Phone Number (  )  - _____

Rx Number or Drug Name(s) (separate each with a comma):

_____

☐ Please contact my prescriber for a new prescription

Doctor's Name: _____

Doctor's Phone Number: (  )  - _____

Drug name(s) (separate each with a comma):

_____

# State of Wyoming
# Department of Health

## NOTICE OF PRIVACY PRACTICES

Original Implementation Date: April 14, 2003
Revision Effective Date: July 1, 2013

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice is available in alternate formats that meet guidelines for the Americans with Disabilities Act (ADA). To request an alternate format, contact the Wyoming Department of Health (WDH) by telephone at (307) 777-7656, by teletype at (307) 777-5648, or by facsimile at (307) 777-7439.

The WDH provides many types of health-related services, programs (e.g., children's special health), and plans (e.g., Medicaid) which require collection or creation of sensitive client information, also known as protected health information (PHI). WDH is required by both state and federal law to maintain the privacy of its clients' PHI, to provide notice of its legal duties and privacy practices with respect to PHI to its clients, and to notify affected individuals following a breach of unsecured PHI.

This notice of privacy practices (NoPP) describes how WDH may use or disclose your PHI. WDH is required to follow the terms of its most current NoPP. WDH may change its NoPP. A copy of the new NoPP will be posted at all WDH facilities and on the WDH website as required by law. Changes to the NoPP may apply to both your existing and future PHI and records. You can obtain a copy of the current NoPP from any WDH facility or on-line at www.health.wyo.gov.

### Use and Disclosures Without Your Authorization

- **For treatment**. WDH may use or disclose PHI to health care providers who are involved in your health care. For example, PHI may be shared to create and carry out a plan for your treatment.

- **For payment**. WDH may use or disclose PHI to receive payment or to pay for the health care services you receive. For example, WDH may provide PHI to bill your health plan for health care provided to you.

- **For health care operations**. WDH may use or disclose PHI to manage its programs and activities. For example, WDH may use PHI to review the quality of the services you receive.

- **For underwriting purposes.** WDH, in its capacity as a health plan, may use or disclose PHI for underwriting purposes. However, WDH may not use PHI that is genetic information for such purposes.

- **For appointments and informative purposes**. WDH may send you reminders for medical care or checkups. WDH may send you information about health services that may be of interest to you.

- **For public health activities**. WDH may use or disclose PHI to maintain vital records and track some diseases as required by law.

- **For health oversight activities**. WDH, in its capacity as a health oversight agency, may use or disclose PHI to inspect or investigate health care providers. WDH may disclose PHI to another health oversight agency for oversight activities authorized by law (e.g., to a health oversight agency conducting an audit of WDH).

- **As required by law and for law enforcement**. WDH may disclose PHI when required by law or court order, or pursuant to law enforcement investigations.

- **For government programs**. WDH may disclose PHI to other government programs that manage eligibility for public benefits/assistance.

- **To avoid harm**. WDH may disclose PHI to law enforcement to avert a serious threat to the health and safety of a person or the public.

- **For research**. WDH may use PHI to conduct studies and develop reports. However, these reports do not identify specific people.

- **To family, friends, and others**. WDH may disclose PHI to your family or other persons involved in your medical care.

## Uses and Disclosures That Require Your Written Authorization

- **For situations not previously listed.** WDH will ask for your written authorization before using or disclosing your PHI. You may revoke this authorization in writing at any time. WDH cannot take back any uses or disclosures already made with your authorization.

- **Uses and disclosures which specifically require your authorization.** Except in limited circumstances, WDH must obtain your written authorization prior to any uses or disclosures of psychotherapy notes, of PHI for marketing purposes, or of PHI for the sale of that PHI. For marketing or sale of PHI, the authorization must inform you if WDH will receive direct or indirect payment from a third party.

- **Other laws protect PHI.** Many WDH programs are subject to additional laws regarding the use and disclosure of your health information. For example, you must give written authorization for WDH to use and disclose your mental health and chemical dependency treatment records.

## Your PHI Privacy Rights

- **Right to see and get copies of your records.** In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

- **Right to request to correct or update your records.** If you feel your records are inaccurate, you may ask WDH to change or add missing information. You must make the request in writing, and provide a reason for your request. WDH is not required to agree to the request.

- **Right to get a list of disclosures.** You have the right to ask WDH for a list of disclosures of your PHI made within the last six (6) years. You must make the request in writing.

- **Right to request restrictions on uses or disclosures of your PHI.** You have the right to ask WDH to restrict how your PHI is used or disclosed. You must make the request in writing and tell WDH what PHI you want to restrict and to whom you want the restriction to apply. WDH is generally not required to agree to a requested restriction. However, WDH must agree to your request to restrict uses and disclosures of PHI to a health plan (e.g., health insurance company) when you or someone other than the health plan has paid WDH for a health care item or service, unless the use or disclosure is required by law. Once a restriction is implemented, you can request either verbally or in writing that the restriction be terminated.

- **Right to revoke permission**. If you are asked to sign an authorization to use or disclose your PHI, you may cancel the authorization at any time. You must make the request in writing. This will not affect PHI already shared by WDH.

- **Right to choose how we communicate with you**. You have the right to ask WDH to share information with you in a certain way or in a certain place. For example, you may ask WDH to send information to your work address instead of your home address. You must make this request in writing. You do not need to explain the reason for your request.

- **Right to file a complaint**. You have the right to file a complaint if you do not agree with how WDH has used or disclosed your PHI.

- **Right to get a paper copy of this notice**. You have the right to ask for a paper copy of this notice at any time.

## How to Contact WDH to Review, Correct, or Restrict Your PHI

You may contact your local WDH program office to:

- ✓ Ask to look at or copy your records.
- ✓ Ask to correct or change your records.
- ✓ Ask to restrict uses or disclosures of your PHI.
- ✓ Ask for a list of the times WDH disclosed your PHI.
- ✓ Ask to revoke your authorization to disclose PHI.
- ✓ File a complaint.

WDH may deny your request to look at, copy or change your records. If WDH denies your request, WDH will send you a letter explaining why your request is being denied and how to ask for a review of the denial. You will also receive information about how to file a complaint with WDH or with the U.S. Department of Health and Human Services.

## How to File a Complaint or Report a Problem

You may contact any of the people listed below if you want to file a complaint or report a problem with how WDH has used or disclosed your PHI. Your benefits will not be affected by any complaints you make. WDH cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something you believe is unlawful.

## For More Information

If you have any questions about this notice or need more information, please contact the WDH Privacy/Compliance Officer.

De Anna Greene, CIPP/US, CIPP/G, CIPP/IT
WDH Privacy/Compliance Officer
Wyoming Department of Health
401 Hathaway Building
Cheyenne, WY 82002
Phone: (307) 777-8664
Fax : (307) 777-7439
E-mail: deanna.greene@wyo.gov

Region VIII - Office for Civil Rights
U.S. Department of Health and Human Services
999 18th Street, Suite 417
Denver, CO 80202
Voice Phone (800) 368-1019
FAX (303) 844-2025
TDD (800) 537-7697

# Acknowledgement of Receipt of Notice of Privacy Practices

**PLEASE REVIEW CAREFULLY**

The Notice of Privacy Practices explains how WDH may use or disclose information. Not all situations may be described. WDH is required to furnish its clients with a notice of privacy practices pertaining to information we use, maintain and disclose.

I, _____ ***(client's name),*** have received a copy of the WDH Notice of Privacy Practices and have had an opportunity to ask questions regarding how my information will be used.

_____ _____

Client's Signature Date

_____ _____

Client's Legal or Personal Representative Relationship

---

***For Office Use Only:***

Please have this document completed and signed by the individual receiving the Notice of Privacy Practices. Provide one copy to the individual; file the original in their case record.

Completed form received by: _____

Acknowledgement refused

Efforts to obtain acknowledgment: _____

_____

_____

Reasons why not obtained: _____

_____

_____

# Instructions for Proofs of Income and Residency

## Proof of Income:

a) Include a copy one of the following: paystubs (at least 1 months' worth), tax returns, child support, disability, social security, unemployment, retirement, etc. Paystubs are preferred; please use your most recent tax return only as a last resort

b) All documents reflecting income shall include your name and/or address, date, and payment frequency/date ranges (to verify that the income belongs to the applicant and that the income is current).

c) Income will be dependent on marital status:

   a. If you are single, only provide proof of your income

   b. If you are married, you must provide proof of your income and your spouse's income

d) Documents should be dated within the last 6 months (except tax returns)

e) If you currently have no source of income, please fill out the "Statement Regarding No Income" form (page 11).

   a. List sources of income (food, housing, transportation). Sources could be friends/family, taking the bus/walking, SNAP benefits for food, savings, etc. You cannot leave sources blank or list "self"

## Proof of Residency:

a) Include a copy of a utility bill, rent receipt, or tenant (lease) agreement
   a. Preferred utility bills would be an electric, water/trash/sewer, or gas bill
   b. Rent receipts must include your name, address, date, signature, and payment amount.
   c. Tenant (lease) agreements must include your name, address, date, signature, and lease term dates

b) Driver's licenses or cell phone bills are not acceptable

c) Documents should be dated within the last 6 months

d) If you currently do not pay rent and/or utilities at your residence and live with someone else (or are in a shelter/facility), please fill out the "Residency Verification" form (page 12).

   a. Both you and the person listed on the utility bill or tenant agreement must sign the form; if you live in a shelter/facility, then a facility director shall sign the form.

   b. You must provide a utility bill, rent receipt, or tenant (lease) agreement in the person's name that you reside with; if you live in a shelter/facility, no additional documentation is needed (facility director's signature is sufficient).

Wyoming Department of Health
Wyoming Medication Donation Program

# Statement Regarding No Income

**Use this form if you do not receive ANY income**

Phone: 307-635-1297
Fax: 307-635-2156

I, _____, am currently unemployed.
(Please print your first and last name)

By signing this form I attest that I do not have any income from any origin (i.e. spouse's income (if married), child support, social security, VA benefits, unemployment benefits, workmen's compensation, disability, tax return, pay stubs, retirement/pension payments, other Investments, etc.)

I have funds available to cover my expenses from the following sources:

My **HOUSING** expenses are covered by _____

My **FOOD** expenses are covered by _____

My **TRANSPORTATION** expenses are covered by _____

My **OTHER** expenses are covered by _____

Proof of income must be provided. This includes: spouse's income (if married), child support, social security, VA benefits, unemployment benefits, workmen's compensation, disability, tax return, pay stubs, retirement/pension payments, other Investments, etc.

_____ _____
Patient Signature Date

Medication Donation
Don't let unused medicine go to waste

Wyoming Department of Health
Wyoming Medication Donation Program

# Residency Verification

**Use this form if you do NOT pay rent/utilities at your residence**

Phone: 307-635-1297
Fax: 307-635-2156

I, _____, am currently staying with
(Please print name of person applying for Medication Program)

☐ A friend, family, or roommate who pays rent/utilities.

_____
(Please print name of family, friend, roommate, etc. whom you are staying with)

☐ In a Shelter, Treatment Facility, or other Residential Facility.

_____
(Please print name of Shelter/Treatment Facility, etc.)

At this Address:

_____
(Address of household/ Shelter/Facility, etc., with City, State, Zip Code)

_____ _____
**Signature** of family member/friend/roommate OR shelter director, etc. Date

_____ _____
**Signature** of person applying for the Medication Program Date

Proof of residency in the name of the person you are staying with must be provided

Please send a copy of **ONE** of the following with your application:

**Check one:**
☐ Utility bill
☐ Rent receipt
☐ Tenant Agreement

*Note: If you are in a shelter/treatment facility, etc., the signature of the Director will be sufficient for proof of residency.